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FIRST REPORT OF INJURY

IMPORTANT: This section must be com-

NON-RESPONSIVE

Date of Claimed Injury
23 8666641
Employer's Minnesota Withholding Tax Number

SEND THIS REPORT IN TRIPLICATE TO:

EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN

P. O. BOX 1357 • MINNEAPOLIS, MINNESOTA 55440 • PHONE (612) 927-7961

INSURER'S MINNESOTA WITHHOLDING TAX NUMBER 866379

WE WILL FILE A REPORT WITH THE MINNESOTA WORKMEN'S COMPENSATION COMMISSION WHEN NECESSARY.

NON-RESPONSIVE

EMPLOYEE

NON- ex M ☒ F ☐ Occupation DAY WORKER

4. Marital status-Single ☒ Married ☐ Separated ☐ Divorced ☐
5. Type of employment: Full-time ☒ Part-time ☐ Seasonal ☐ Volunteer ☐ If other, specify
6. Type of work program, if applicable: Apprentice ☐ GI ☐ If other, specify
7. Average earnings per week $ 118.40. Check if earnings are based on piece work. ☐
8. Straight-time worked: Hours per day 8 Number of days worked per week 5
9. Average over-time worked: Hours per day Number of days worked per week
10. Straight time rate: $ 2.96 per hour. Over-time rate: $ per hour.
11. If part-time worker, state total amount earned, total number of days worked and total number of weeks worked in the last 26 weeks. $ days weeks Number of hours normally worked by full-time employees per week
12. If furnished in addition to wages, state weekly value of: Board $; Lodging $; Other $
13. Did employee have other regular employment at time of injury? If yes, where?

2960

EMPLOYER

14. Employer REILLY TAR & CHEMICAL CORP. PLANT # 2 Tel. No. 929-7551
15. Type of ownership: Individual ☐ Partnership ☐ Corporation ☒ If other, specify
16. Employer's address 7200 WALKER STREET
City ST. LOUIS PARK State MINNESOTA Zip Code 55426
17. Name of employer representative or supervisor who first received knowledge of injury B. GRAHAM
18. Date when notice was received 10-23-70 Time of day injury occurred 9:45 A.M. P.M.
19. Location where injury occurred LUMBER YARD

NATURE AND EXTENT OF INJURY OR DISEASE

20. Nature of claimed injury or disease RASH ON PALM OF RIGHT HAND
21. Did claimed injury or disease cause loss of time? Yes ☒ No ☐ If yes, last day worked? 10-22-70
22. Were full wages paid for last day worked? Yes ☒ No ☐
23. Has employee returned to work? Yes ☒ No ☐ If yes, when 10-27-70
24. If injury or disease resulted in death to employee complete the following: Date of death
Name of dependent or next-of-kin Relationship
Address

MEDICAL AND HOSPITAL

25. Name of treating physician ST. LOUIS PARK MEDICAL CENTER Tel. No. 927-3123
Address 5000 WEST 36th STREET ST. LOUIS PARK, MINN.
26. Hospital Address
27. Did employer authorize medical treatment? Yes ☒ No ☐

CAUSE OF INJURY

28. Describe how injury occurred HANDLING TREATED LUMBER
29. Machine, tool or appliance causing injury TREATED LUMBER
30. Did any employee physical handicap contribute to cause of injury? Yes ☐ No ☒ If yes, how?
31. What action has been taken to prevent recurrence?

Dated NOVEMBER 16, 19 70
(OBSERVE INSTRUCTIONS ON REVERSE SIDE.)

Signed by 3509122
Official Title PLANT MANAGER
Phone No. 929-7551

WC 102 Rev 1969 Replaces C1 which shall not be used